Adult Attendant Care Services (18 and over)

Definition: Assistance related to the performance of activities of daily living and/or instrumental activities of daily living and personal care which may include hands-on care, of both a medical and non-medical supportive and health related nature, specific to the needs of a medically stable adult with physical and/or cognitive disabilities whom is able to self-direct their own care or has a responsible party that is able to direct their care. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. Housekeeping activities provided under attendant care are specified to the plan of care and are incidental to the care furnished, or are essential to the health and welfare of the adult. Any community access activities must be directly related to the recipient's care and must be specified in the plan of care.

Providers: Attendant Care Services may be provided by an attendant enrolled with SC DHHS under the UAP Attendant Care Program. The Policies and Procedures of that service must be followed and the attendant must meet the DDSN minimum qualifications as specified in the MR/RD Waiver Document. Procedures for the UAP Attendant Care Program are attached at the end of this chapter.

Relatives/ family members of a waiver recipient may be paid to provide Adult Attendant Care Services as specified in DDSN policy 736-01-DD.

Arranging for the Service: If the Service Coordinator determines that a waiver participant is in need of Attendant Care Services or if the participant requests Attendant Care Services, the Service Coordinator should discuss self-directed and/ or responsible party care with the participant/ representative. The need for the service must be supported in the participant's plan. In order to assist the Service Coordinator in assessing the need for Attendant Care Services the Personal Care needs assessment (MR/RD Waiver Form 34) must be completed.

Once Attendant Care Services are chosen, the amount and frequency of the service is determined, Attendant Care Services can be added on to the Waiver Tracking System. Attendant Care services cannot be approved at the local level. SCDDSN Central Office will have final approval authority on all budget requests for Attendant Care Services. The MR/RD Waiver Personal Care Needs Assessment (MR/RD Form 34) must be submitted to the appropriate District MR/RD Waiver Coordinator for review upon adding Adult Attendant Care Services to the Waiver Tracking System. When the service is approved the Service Coordinator will proceed with making a referral (**not authorizing services**) to the UAP Attendant Care Program.

The MR/RD waiver document requires, as a part of the minimum qualifications, an attendant must receive training in basic First Aid prior to the provision of Attendant care services. The attendant must also receive refresher training every three (3) years. The Service Coordinator and participant or Responsible Party will need to aid the potential attendant in locating an acceptable First Aid training program and competency must be demonstrated. Once the course/training is completed, UAP must be notified and provided documentation that the requirement has been met.

Note: Follow the UAP Attendant Care procedures for complete details on the referral process.

Service Authorization:

Once an attendant is located and UAP has approved the "match", Attendant Care Services can be authorized. The authorization is made out to the DDSN Provider not UAP. The Authorization for UAP Attendant Care Services (MR/RD Form A-37) will be faxed or mailed to:

Attendant Care Service
Center for Disability Resources
Department of Pediatrics
USC School of Medicine
Columbia SC 29208
803-935-5250 (fax)

A copy will also be provided to the participant/responsible party, attendant and Richard Wnek, SCDDSN, Director, Cost Analysis. Upon receipt of MR/RD Form A-37, the DDSN Attendant is authorized to provide the service. This authorization is in effect until a new/revised MR/RD Form A-37 is sent or until services are terminated.

The number of hours authorized is based on the participant's needs. The Service Coordinator will authorize the total units for the week and the participant/responsible party and attendant are responsible for negotiating the times of service. When more than one attendant is authorized to provide services, all providers will be authorized for the full number of hours. The schedule of hours is up to the participant/ responsible party and attendant. The participant and attendant are instructed that billing for hours over the number of hours authorized will result in non payment.

Monitoring the Services: You must monitor the service for effectiveness, frequency, duration, benefits, usefulness and the participant's satisfaction of the service. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following criteria should be followed when monitoring Adult Attendant Care Services:

- Within two weeks of start of service while the service is being provided. Unless a supervisor makes an exception. An exception is defined in the following circumstances:
  - The service is only provided in the early morning hours (prior to 7:00 am)
  - The service is only provided in the late evening hour (after 9:00pm)
  - The exception and approval by the supervisor must be documented. No other exceptions will be allowed.
- At least once during the second month of service
- At least quarterly thereafter
- Start over with each new provider
- Yearly on site monitorship required

This service may be monitored during a contact with the individual/family or service provider. It may also be monitored during a review of medical assessment/notes regarding treatment provided. Some items to consider during monitorship include:

→ Has the individual's medical status changed since your last contact?
→ Review the attendant care time sheets to ensure hours and services are being provided as authorized.

- → Are all applicable services being provided as discussed?
- → Is the individual satisfied with the result of this service?
- → Does the individual feel that the provider is responsive to their needs?
- → Does the individual feel that there is a good relationship with the attendant?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the consumer or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). The general termination form that has been used in the past for all waiver services is no longer used. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

Mental Retardation/Related Disabilities Waiver
Personal Care (PCI and PCII)/ Attendant Care Assessment

MR/RD Waiver Recipient: _____

Social Security Number: _____

Age:_____ **Service Requested** ☐ PCI ☐ PCII ☐ Attendant Care

I. Personal Care Needs

Bath: Bed ☐ Shower/Tub ☐ Partial Assist ☐ Total Assist ☐ Frequency and Time Required_____

Shaving: Partial Assist ☐ Total Assist ☐ Frequency and Time Required_____

Oral Hygiene: Partial Assist ☐ Total Assist ☐ Frequency and Time Required _____

Skin Care: Partial Assist ☐ Total Assist ☐ Frequency and Time Required _____

Dressing and Grooming: Partial Assist ☐ Total Assist ☐ Frequency and Time Required_____

Incontinence Care: Partial Assist ☐ Total Assist ☐ Frequency and Time Required_____

Toileting: Partial Assist ☐ Total Assist ☐ Frequency and Time Required_____

Positioning and Turning in Bed: Partial Assist ☐ Total Assist ☐ Frequency and Time Required_____

Medication Monitoring: Partial Assist ☐ Total Assist ☐ Frequency and Time Required_____

Other Medical Monitoring:

_____ Partial Assist ☐ Total Assist ☐ Frequency and Time Required_____

_____ Partial Assist ☐ Total Assist ☐ Frequency and Time Required_____

Exercise Partial Assist ☐ Total Assist ☐ Frequency and Time Required_____

Ambulation/Escort Services: Distance _____ Frequency and Time Required_____

Transfers:

Hoyer ☐ Sliding Board ☐ Lift System ☐ Other _____

Partial Assist ☐ Total Assist ☐ Frequency and Time Required_____

Other Personal Care Needs:

_____ Partial Assist ☐ Total Assist ☐ Frequency and Time Required_____

_____ Partial Assist ☐ Total Assist ☐ Frequency and Time Required_____

II. Meal and Dining Needs

Preparation and Set-Up Partial Assist ☐ Total Assist ☐

Frequency: and Time Required Breakfast_____ Lunch _____ Dinner_____

Feeding Partial Assist ☐ Total Assist ☐

Frequency: and Time Required Breakfast_____ Lunch _____ Dinner_____

Clean Up Partial Assist ☐ Total Assist ☐

Frequency: and Time Required Breakfast_____ Lunch _____ Dinner_____

III. General Housekeeping Needs (not appropriate for children under the age of twelve)

Vacuuming Recipient's Room/Area:	Daily ☐	Weekly ☐	Monthly ☐	Time Required_____
Sweeping Recipient' Room/Area:	Daily ☐	Weekly ☐	Monthly ☐	Time Required_____
Dusting Recipient's Room/Area:	Daily ☐	Weekly ☐	Monthly ☐	Time Required_____
Mopping Recipient's Room/Area:	Daily ☐	Weekly ☐	Monthly ☐	Time Required_____
Cleaning Recipient's Bathroom:	Daily ☐	Weekly ☐	Monthly ☐	Time Required_____
Cleaning Recipient's Bedroom:	Daily ☐	Weekly ☐	Monthly ☐	Time Required_____
Recipient's Laundry:	Daily ☐	Weekly ☐	Monthly ☐	Time Required_____

IV. Other Needs:

Shopping Assistance*:	Errands	Daily ☐	Weekly ☐	Monthly ☐	Time Required _____
	Escort	Daily ☐	Weekly ☐	Monthly ☐	Time Required_____

*__not appropriate for recipients under age eighteen__

Assistance with Communication:	Daily ☐	Weekly ☐	Monthly ☐	Time Required_____

V. Requested Schedule for Personal Care or Attendant Care Services:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Total Units Needed Daily:_____

Total Units Needed Weekly:_____

Total Units of Personal Care I/ Personal Care II/Attendant Care Services recommended_____ per day/week/month

Include justification for or against recommended amount of Attendant Care: _____

_____

_____

_____

_____ _____

Signature of Person Completing Assessment **Title**

_____

Date

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR UAP ATTENDANT CARE SERVICES

TO:_____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

_____
Phone Number

Medicaid # /____/____/____/____/____/____/____/____/____/____/____/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

_____ **MR/RD UAP Attendant Care**

Start Date: _____ / _____ / _____

Authorized Total: _____ **Units per week (one unit = 1 hour)**

Service Tasks Requested:

- ☐ Assistance with personal care activities such as bathing, dressing, toileting, brushing teeth, grooming, shampooing hair,caring for skin, etc.
- ☐ Assistance with meals such as feeding, shopping for food, preparing/cooking meals, post-meal cleanup, etc.
- ☐ Assistance with home care/light housekeeping tasks such as sweeping, light laundry, bed making, changing bed linens, etc.
- ☐ Monitoring conditions such as temperature, checking pulse rate, observation of respiratory rate, checking blood pressure, monitoring medications, etc.
- ☐ Assistance with exercise, ambulation, positioning, etc.
- ☐ Errands and/or escort services (not to include transportation)

Service Coordinator: Name / Address / Phone # (Please Print):

_____

_____

_____

Signature of Person Authorizing Services Date

MR/RD Form A-37 (7/08)